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Service Records Resource Manual

For Area Programs and Contract Agencies

NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Mental Health, Developmental Disabilities,
and Substance Abuse Services

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Department of Health and Human Services
Division of Mental Health, Developmental
Disabilities and Substance Abuse Services

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Appendix A

Sample Crisis Prevention/Crisis Response Plan

SAMPLE CRISIS PREVENTION/CRISIS RESPONSE PLAN

Tom S. is a thirty-four year old man who lives at 207 Bunch Street, Durham, NC The telephone number is (919) 286-7777.

Tom has the following diagnoses:

Axis I: Bipolar Disorder, NOS (296.80)
Impulse Control Disorder, NOS (312.30)
Axis II: Moderate Mental Retardation (318.0)
Axis III: None Reported

Tom receives the following medications:

Depakote - 250 mg. QID - Behavior Control
Ativan - 1 mg. TID - Anxiety

Tom's target behaviors could at any point in time lead to a potential crisis situation: agitation, verbal and physical aggression, property destruction, self-injurious behavior, AWOL, and explosive/disruptive behavior.

When Tom's target behaviors increase to a level that requires more than minimal redirection, support staff should implement the following:

Level I. - Prevention

A. Follow Behavior Guidelines (Please see attached)
B. Provide opportunities for socialization (i.e. offer choices of activities to decrease anxiety levels).
C. Staff should monitor for signs of destabilization (see check sheet).
D. Psychologist, support staff, QDDP, and Case Manager will meet to review data and progress.
E. Review environmental stress factors. Problem-solve in a timely manner.
F. Contact Area Program Management staff (QDDP, Residential Services Director, Nurse, and Administrator) to request Psychological review.

*When all preventive measures have not been effective, the team will

need to meet to discuss implementation of intervention level II.

Level II. - Intervention

A. Schedule a timely meeting to include Guardian and Case Manager.
B. Increase staff supervision in the home.
C. Contact the psychologist regarding timely behavior intervention changes.
D. Psychologist will contact the psychiatrist regarding medications.

*When all intervention measures on Level II have failed, then staff will seek hospitalization.

Level III. - Crisis Stabilization

A. Contact Guardian and Case Manager regarding hospitalization.
B. Seek hospitalization through Durham MHC. Assistance should be requested from the assigned emergency staff. Hospital Preferences: Durham Regional, Duke, and UNC.
C. Case Manager, QDDP, Residential Services Director, etc. Will meet with the team on the inpatient unit. Case Manager and Group Home staff will monitor Tom's progress on the inpatient unit on a weekly basis.
D. Provide support staff on the inpatient unit if necessary.
E. The team will develop a discharge plan with the inpatient unit for Tom's return to the community.

*All staff are inserviced on the Crisis/Back-Up Plan, Behavior Guidelines, and any other training specifically related to meet Tom's needs.

***Important Contacts**

- Behavior Healthcare After-hours - (919) 286-1138
- Durham Developmental Services - (919) 286-2932, EXT. 23
- George Young, Thomas S. Case Manager - (Pager#) (919) 286-4132
- Marty Jones, Group Home Operator - (919) 286-0446
- Durham Regional Medical Center - (919) 286-5858 - Sara Emory, RN
- Duke Hospital - (919) 286-4000 (Admitting Office)
- UNC Memorial Hospital - (919)933-425 (Admitting Office)

Appendix B

DOCUMENTATION NEEDS FOR CONSUMERS WITH DUAL DIAGNOSES

DOCUMENTATION NEEDS FOR CONSUMERS WITH DUAL DIAGNOSES

Providing appropriate services to individuals with dual diagnoses promote the need for an integrated service delivery system. Historically, these individuals frequently received fragmented and ineffective care due to multiple reasons, including being diagnosed and treated according to the nature of the initial presenting problem.

In order to coordinate best practice efforts both in service delivery and in documentation, the following is recommended:

1. Develop a screening device which includes questions to identify both mental illness, developmental disabilities, and substance abuse disorders. An example of a screening device for substance abuse and mental illness is located on the following page.
2. Diagnostic updates should incorporate mechanisms for screening for dual diagnoses.

SAMPLE SCREENING QUESTIONS TO IDENTIFY THE SYMPTOMS OF DRUG ABUSE AND MENTAL ILLNESS

. ALCOHOL AND DRUG ABUSE:

1. How has your alcohol or drug use changed over the past 3 months/6 months/1 year?
   Note: You are looking for patterns of relief?
2. Have you ever been to a party/social occasion without using drugs or alcohol?
   Note: Looking for relief or escape use.
3. Are there any times or occasions that you used drugs and you have a hard time remembering what occurred? Note: You are looking for blackouts, impaired memory, judgment.
4. Have you ever been arrested for drunk driving or other arrest? Note: Looking for legal/court involvement.
5. What was your blood alcohol level? Note: Looking for indications of tolerance.
6. Can you think of a particularly negative/bad experience that happened to you recently? Were you drinking or drugging at the time? Note: Establishing consequences to use.
7. How do your family, friends, coworkers, react to your drug use/drinking? Has anyone ever complained about it? Note: Establish the impact on social network and level of functioning, and any perceptions of guilt.
8. Have you ever stopped using or tried to limit your use to a specific amount? Note: Establish a deeper felt concern about use.
9. Do you have any medical problems, physical symptoms, recent accidents? Note: Looking for physical symptoms of drug abuse and situational symptoms; i.e., frequent accidents.
10. If you ever stopped using drugs or alcohol did you ever experience seeing things that were unusual, bizarre, or scary? Did you have a strong craving to use? Note: Looking for withdrawal symptoms.

. PSYCHIATRIC DISORDERS:

DEPRESSION

1. Did your feeling of depression predate your use of alcohol? Describe how you feel when you are depressed. Note: Looking to examine the intensity and depth of the depression and whether the depression predates the alcohol or drug use.
2. Do you have difficulty eating, sleeping, concentrating, or making decisions? Note: These are often signs of endogenous depression.
3. Have you suffered any recent losses that may have contributed to your feeling sad or depressed? Note: Withdrawal from alcohol and drugs often causes feelings of grief. These feelings of loss need to be distinguished from those caused from life events.
4. Do you ever think about a specific plan of committing suicide? If so, could you describe the details of this plan? Note: Any indication of a specific plan is cause for alarm and indicates the potential for acting on the plan.

MANIA

Have you ever found yourself feeling unable to sit still, very talkative, unable to concentrate on one thing or idea, very irritable or very anxious? Note: Try to find out if the person is on stimulant drugs because these can produce the same symptoms.

PSYCHOSIS

1. Have you ever seen things or colors that you were not sure were there? Have you ever heard a voice or voices that you were not sure were really there? Can you describe them? Do the voices, visions change frequency or duration when you drink or drug? Note: Looking for evidence of auditory or visual hallucinations, and specifically a description of these hallucinations. Auditory hallucinations are more common with schizophrenia, while visual hallucinations of small things - bugs, bats, etc. - crawling or flying around are common with alcohol hallucinosis.
2. How do you think we can help you? Note: Look for evidence of inability to concentrate, tangential thinking, or delusional thinking, but also what they really want.
3. What happens when or if you take your medication? Do you have any side effects? How do you feel when you take your meds? Note: Looking for whether the client is medication compliant, or if they are relying on street drugs to self-medicate.

LEVELING OF FUNCTIONING

1. Do you receive SSI?
2. How do you pay for your drugs?
3. Have you ever stopped using drugs or alcohol for more than three or four weeks?
4. Are you working?
5. Where do you live?

Appendix C

MEDICARE DOCUMENTATION PARTIAL HOSPITALIZATION

MEDICARE PART A-PARTIAL HOSPITALIZATION

The following requirements are applicable to partial hospitalization services provided by an area program for which Medicare-Part A is billed.

SCOPE OF PARTIAL HOSPITALIZATION BENEFIT

To be considered eligible for payment under the Medicare partial hospitalization benefit, the services must be:

- Reasonable and necessary for the diagnosis or active treatment of the individual's condition; and
- Reasonably expected to improve or maintain the individual's condition and function level to prevent relapse or hospitalization. A partial hospitalization program for Medicare purposes is a comprehensive structured program that uses a multidisciplinary team to provide comprehensive coordinated services within an individual treatment plan to individuals diagnosed with one or more psychiatric disorders.

There are two critical points which affect the determination of coverage for partial hospitalization services:

1. the initial decision as to the medical appropriateness of entrance into the program for treatment; and
2. the decision about discharge. Both determinations should take into account both the diagnosis and the individual's treatment needs.

Partial hospitalization programs are designed to treat patients who exhibit severe or disabling conditions related to an acute psychiatric/psychological condition or an exacerbation of a severe and persistent mental disorder.

Partial Hospitalization may occur in lieu of either:

- admission to an inpatient hospital; or
- a continued inpatient hospitalization.

Treatment may continue until the patient has improved sufficiently to be maintained in the outpatient or office setting on a less intense and less frequent basis. This is an individual determination.

Persons who require a low frequency of participation may indicate that the partial hospitalization program is no longer reasonable and necessary and he/she could be managed in an outpatient setting and should no longer be covered in the partial hospitalization program.

A partial hospitalization program differs from inpatient hospitalization and outpatient management in day programs (i.e., adult day programs or psychosocial programs) and periodic office visits for management of medication and psychotherapy in:

- the intensity of the treatment programs and frequency of participation by the patient; and
- the comprehensive structured program of services provided that that are specified in an individualized treatment plan which is formulated by a physician and the multidisciplinary team with the patient's involvement.

Active treatment refers to the ongoing provision of clinically recognized therapeutic interventions which are goal-directed and based on a documented treatment plan. Examples of active treatment include, but are not limited to; individual therapy, group therapy, and occupational therapy. In order to be considered active treatment, the following criteria must be met:

- Treatment is directed toward the alleviation of the impairments that precipitated entrance in the program or which necessitate continued level of intervention;
- Treatment enhances the patient's coping abilities, and
- Treatment is individualized to address the specific clinical needs of the patient.

Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

ELIGIBILITY

In order for a Medicare patient to be eligible for a partial hospitalization program, a physician must certify (and recertify where such services are furnished over a period of time):

1. That the individual would require inpatient psychiatric care in the absence of such service.

   This certification may be made where the physician believes that the course of the patient's current episode of illness would result in psychiatric hospitalization if the partial hospitalization services are not substituted.
2. An individualized plan for furnishing such services has been established by a physician and is reviewed periodically by a physician, and
3. Such services are or were furnished while the individual is or was under the care of a physician.

A Medicare partial hospitalization program is an appropriate level of active treatment intervention for individuals who:

1. Are likely to benefit from a coordinated program of services and require more than isolated sessions of outpatient treatment. Partial hospitalization is the level of intervention that falls between inpatient hospitalization and episodic treatment on the continuum of care for the mental ill;
2. Do not require 24-hour care and have an adequate support system outside the hospital setting while not actively engaged in the program;
3. Have a diagnosis that falls within the range of ICD-9 codes for mental illness (i.e., 290 through 319). However, the diagnosis in itself is not the sole determining factor for coverage; and
4. Are not judged to be dangerous to self or others.

INDIVIDUALS WHO ARE INELIGIBLE FOR MEDICARE PARTIAL HOSPITALIZATION PROGRAMS

1. Patients who refuse or who cannot participate (due to their behavioral, cognitive, or emotional status) with the active treatment process or who cannot tolerate the intensity of the partial hospitalization program;
2. Patients who are gravely suicidal, homicidal, or severely demented that require 24-hour supervision and present significant security risks;
3. Patients who demonstrate inadequate impulse control manifested by self-mutilating or self-destructive behavior requiring 24-hour supervision;
4. Patients who require primarily social, custodial, recreational or respite care (e.g., moderately to severely demented patients with no evidence that active treatment would modify the clinical course);
5. A patient with multiple unexcused absences or a patient who is present and is non-compliant. A patient with multiple unexcused absences is not receiving "active treatment" and, therefore, is not appropriate to participate in partial hospitalization program. A patient who attends sessions and is non-compliant may be in an inappropriate group or may not be at a functional level to understand instructions;
6. Patients who have achieved sufficient stabilization of the presenting symptoms and sufficient intervention in skills or coping ability and mobilization of family and/or community supports to no longer require the intense, frequent involvement of a partial hospitalization program (e.g., a patient who needs only one day a week on an ongoing basis would not need Medicare covered partial hospitalization programs); and
7. Patient who have achieved sufficient stability so that they now require limited intervention (medication management and psychotherapy as an individual or in a group) on an intermittent basis which may be performed in the outpatient or office setting.

CERTIFICATION REQUIREMENTS

In order for an individual's partial hospitalization program to be covered, the following must be certified and recertified by a physician.

1. The individual would require inpatient psychiatric care in the absence of such services;

   NOTE: This certification may be made where the physician believes that the course of the patient's current episode of illness would result in psychiatric hospitalization if the partial hospitalization services are not substituted.
2. The services are or were furnished while the individual was under the care of a physician; and
3. The services were furnished under a written plan of individualized treatment that meets the plan of treatment requirements described in the treatment plan section of this section.

INDIVIDUALIZED TREATMENT

A physician must order the partial hospitalization services, establish the plan of treatment, and periodically recertify the need for continued care. Partial hospitalization services must be prescribed by a physician and furnished under the supervision of a physician.

PHYSICIAN SUPERVISION

Partial hospitalization services require general supervision by a physician. This means that a physician must be at least available by telephone, but is not required to be on the premises at all times.

INDIVIDUALIZED TREATMENT PLAN

Partial hospitalization is active treatment that incorporates an individualized treatment plan, a coordination of services wrapped around the needs of the patient, and a multidisciplinary team approach to patient care.

The individualized treatment plan is established within the first 7 days of a client's participation in the program and periodically reviewed at least every 31 days thereafter by a physician in consultation with appropriate staff participating in the program. The treatment plan must include, but is not limited to:

1. Physician's diagnosis,
2. Treatment goals under the plan,
3. Type of services,
4. Amount of services,
5. Duration of services, and
6. Frequency of services

The treatment goals are the basis for evaluating the patient's response to treatment. Treatment goals should be designed to measure the impact of treatment. Objective treatment goals are vital resources for the determination of whether a partial hospitalization program is the appropriate level of intervention for the individual's condition.

In addition, treatment goals are a tool for determining whether a service is covered. The services rendered to partial hospitalization patients and are linked to specified treatment goals in the individualized active treatment plan may constitute Medicare covered services when provided as components of a partial hospitalization program.

CHART ENTRIES

Chart entries are an appropriate method to document a patient's response to treatment. Chart entries should be written on each day that there is an encounter and should reflect, but are not limited to, the following:

1. Observation of the patient's status and responses in the course of therapeutic contact; and
2. The patient's response to treatment as it relates to the individualized active treatment goals.

The physician determines the frequency and duration of the services taking into account accepted norms of medical practice and a reasonable expectation of improvement in the patient's condition or maintenance of an appropriate functional level.

COVERAGE CRITERIA FOR INDIVIDUAL SERVICES

Covered services furnished under partial hospitalization programs must be reasonable and necessary for the diagnosis or active treatment of the individual's condition, and must be expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization.

For coverage purposes, the key to whether a particular type of group of services and activities may be covered as a partial hospitalization program depends primarily on the services provided in the program and how the services are being utilized in the care of the individual patient.

Eligible individuals must need and receive:

1. A level of active treatment intervention that incorporates a program of partial hospitalization services;

2. A physician's plan of treatment that is individualized and essential for the treatment of the patient's condition;
3. A coordinated multidisciplinary approach to patient care; and
4. Services that are linked to specific treatment goals in the individualized plan of treatment.

The following services may be covered as elements of a partial hospitalization program. A partial hospitalization program is a distinct and organized intensive treatment service offering less than 24-hour daily care. Items and services under a partial hospitalization program may include:

- Individual and group therapy with physicians or psychologists or other mental health professionals to the extent authorized under State law;
- Occupational therapy requiring the skills of a qualified occupational therapist;

  NOTE: An occupational therapy service is covered only if it is a component of the physician's treatment plan for the individual. While occupational therapy may include vocational and prevocational assessment and training, when the services are related solely to specific employment opportunities, work skills or work settings, they are not covered.
- Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients;
- Drugs and biologicals that cannot be self-administered and are furnished for therapeutic services, subject to the limitations specified in 42 CFR 410.29. For example, oral medications that can be self-administered are not covered.
- Individualized activity therapies that are not primarily recreational or diversionary;

  NOTE: The determination of coverage depends on the individual case. Individualized activity therapies that are essential to the treatment of the patient's condition, indicated by a physician in the patient's treatment plan, linked to specified treatment goals in the treatment plan, and are not primarily recreational and diversional can constitute covered elements of a partial hospitalization program.
- For example, when they are individualized and essential for the treatment of the partial hospitalization patient's condition, art therapy, music therapy, movement therapy, stress reduction, conflict resolution, and similar activities may constitute covered activity therapies.
- Providers should not bill for activity therapy services as individual or group psychotherapy services.
- Family counseling, the primary purpose of which is treatment of the individual's condition;

NOTE: The Coverage Issues Manual (CIM) Section 35-14 provides guidance for the coverage of family counseling. This section provides the following covered examples of family counseling services:

1. There is a need to observe the patient's interaction with family member(s); and/or
2. There is need to assess the capability of family members to aid the patient and aid in the patient's management.

- Patient training and education, to the extent the training and educational activities are closely and clearly related to the individual's care and treatment;

  NOTE: Section 80-1 of the CIM provides guidance for the coverage of patient training and education.

- Diagnostic services; and

NOTE: Diagnostic services covered under the partial hospitalization benefit include those:

1. For purposes of diagnosing those individuals for whom an extended or direct observation is necessary to determine functioning and interactions;
2. To identify problem areas; and
3. To modify/formulate a treatment plan.

. Other items and services specified by HCFA

NONCOVERED SERVICES

a) Services are noncovered when the patient's condition would not permit them to participate or to benefit or the patient chooses not to participate;
b) Meals;
c) Transportation;
d) Activities that are primarily recreational or diversional in nature for which the individual participating does not have a specific individual treatment goal. Examples of activities include social hours, television, shopping trips, and attending or participating in sports;
e) Drugs and biologicals that can self-administered;
f) General education programs or education of the general public; and
g) Any service that does not have a specific treatment goal.

***Information above obtained from October 1995 Medicare Bulletin. (See bulletin for additional information.)**

Appendix D

MEDICARE DOCUMENTATION OUTPATIENT

Appendix E

SECURITY OF RECORDS

SECURITY OF RECORDS

Policies to ensure the safeguard of service records (both electronic and paper) shall be developed. Although many area programs are not at the point of implementing electronic client records, most area programs do utilize a fax machine and many have e-mail capabilities.

The following are recommended practices for the protection of paper records:

a) All service records should be maintained in a secured location with either locked files or in a room which can be locked;
b) Written policies and procedures for a record control system should be established for controlling the removal and return of all service records from the record department or other secured and controlled storage area;
c) Staff who remove a service record from the record department or other secured and controlled storage area are legally responsible for the safety and contents of the record; and
d) Once information has been correctly placed in a service record, such information should remain a permanent part of the record. Reports should be proofread and corrected before they are signed as the final copy and filed in the client record.
    - Employees and other individuals who have access to client information should receive specific training regarding the confidentiality of client information.

The following sections provide recommendations for protecting electronic information:

MINIMIZING SECURITY AND CONFIDENTIALITY RISKS IN ELECTRONIC INFORMATION

There are many aspects to consider in protecting the confidentiality of computer-based health information.

The following areas, although not inclusive, should be considered as area programs and contract agencies protect electronic information:

. Training
    1. Employees and other individuals who have access to client information should receive specific training regarding the confidentiality of client information.
    2. After completing the training, employees and other individuals who have access to client information should sign a statement of understanding and compliance.

. **Security Measures**

1. The facility should determine the classifications of information ("data sets") to which different users may have access, the levels of confidentiality each data set should have and incorporate these principles in a security policy;
2. To minimize the chance of massive theft or destruction of files, software should limit the number of files which can be copied;
3. A health information system also should be prepared to respond to the following threats:

- **physical problems**: Losses may result from power failure, loss of communications, fire, etc. At a minimum, users should be clear of their responsibilities for backing up data and disaster recovery;
- **viruses:** The increasing use of e-mail and Internet access provide fertile ground for the development of new strains of viruses and other malicious code, outpacing the ability of antiviral software programs. Responsibility to avoid co-mingling computer resources should be emphasized.
- **disgruntled employees:** The greatest risk of sabotage to computer systems comes from disgruntled employees. Because of this, it is important that passwords be deleted immediately when an employee resigns or is discharged. In addition, technical programming information should be made available only to those with a legitimate need for access.
- **hackers:** Hackers gain illegal entry into a computer system. Hackers may browse through information or steal, alter, or destroy information. Systems that may be assessed via modem are particularly vulnerable to hacker activity. Audit trails and on-going monitoring of accesses are good ways to reduce this risk.
- **theft:** Desktop and laptop computers and the data they contain are especially vulnerable to theft from inside or outside the organization;
- **errors and omissions:** Users, data entry clerks, system operators, and programmers may make unintentional errors that contribute to security problems by creating vulnerabilities, crashing systems, or compromising data integrity;
- **browsing:** Legitimate users sometimes access information they do not need just to satisfy their curiosity. Extremely sensitive information like HIV test results may be vulnerable if not adequately protected in the system's design.[1]

Brandt, Practice Brief: Security Guidelines, Journal of the American Health Information Management Association (Jun. 1996).

. The system should permit only identified users access to health information, and should track all activity in the files. Following are some security measures to accomplish this:

1. **Passwords** -- The system should be programmed to give the user access to predetermined levels of information.
   - Passwords minimize access and "control processing intent" by limiting users to certain tasks based on controls put on their passwords;
   - Limited users could be given additional passwords to reach special sections of the system;
   - Passwords should be subject to "aging," requiring users to change to new passwords after a certain time has passed. Passwords of more than five characters are harder to guess.
   - Some systems require both sender and receiver to enter a password to retrieve information from a "mailbox" where the information is transferred and held.
   - When a user leaves, his or her password should be de-activated.
2. **Audit trails:** An audit trail is a detailed record of who looked at, entered, or changed data, and when. Audit trails also tell whether the file was altered, browsed, or downloaded.
   - Although they do not prevent unauthorized access, audit trails do provide a disincentive to misuse confidential information because audit trails can identify a culprit.
   - Curiosity is utterly human. To discourage unauthorized browsing by their own authorized users, some facilities have found it useful for audit trails to be automatically viewable on every record so that users accessing the file can see who else was in it and what they did with it. Not only does this lead to reporting of unauthorized access, but it discourages browsing for fear of being "found out."
3. **Callback** - Someone seeking access to a system from a remote location dials into the system from a system-registered phone number, the system verifies whether the number is an authorized one, and if so, calls the user back and permits access to the data. If there is no answer by a modem at the other end, the system denies access to the caller.
4. **Biometrics devices** - A novel but expensive way to prevent unauthorized access. Biometrics devices identify unique human traits like blood vessel patterns in the retina, fingerprints, voice recognition, and real-time signature;
5. **Encryption** - Encryption scrambles data to make it unusable to unauthorized users.
   - Information is "decrypted" when the user hits a key or series of keys known only to authorized users.
   - Hardware encryption is faster and much harder to alter or decode, but is more expensive than software encryption.
   - Encryption also protects information transmitted over public channels of communication like telephone lines, radiowaves and microwaves.[2]

6. To minimize problems and preserve data and system integrity and security, a health information system should have:
   - Documented instructions to users describing data access procedures during scheduled and unscheduled down-time;
   - Vendor contracts which identify specific protections the facility seeks and the date the vendor will implement them;
   - Documented maintenance requirements, procedures, and maintenance logs;
   - Back-up systems such as an alternate power source and off-line data storage;
   - Documented maintenance requirements, procedures, and maintenance logs;
   - Documented disaster recovery procedures.[3]
7. Confidentiality Agreements
   - Every person given an access code should be required to sign a confidentiality agreement requiring preservation of the security, integrity and confidentiality of client information, and prohibiting sharing the access code;
   - Third parties such as computer vendors or repair persons, and their subcontractors, should be required to enter into confidentiality agreements. The agreements should require him to keep records strictly confidential; limit use of records only to those purposes necessary to carry out the contract; require any employees, subcontractors or agents to also sign confidentiality agreements; return any records downloaded or printed; and indemnify the facility for any breach of these obligations.[4]

2

Siwicki, As Networks Multiply, Privacy Concerns Grow, 3 Health Data Management, see also, Adele Waller and Deborah Fulton, The Electronic Chart: Keeping It Confidential and Secure, 26 J. Of Health & Hospital L. 104 (Apr. 1993).

3

Robert Field, Overview: New Legal And Business Confidentiality Problems; 11 Health Span 3 (Sept. 1994)

4

Adele Waller and Deborah Fulton, The Electronic Chart:Keeping It Confidential and Secure.

FAXING CLIENT INFORMATION

Transmitting client information by telecopy makes clinical information immediately available, but also creates opportunities to compromise client confidentiality and affect service record integrity.

The following recommendations are based upon the American Health Information Management Association's guidelines for faxing client information:

1. Facilities should develop policies for sending and receiving client information by fax.
2. Faxes should never be used for routine releases of information, especially when using the original or mail delivery will suffice.
3. A dedicated fax machine for sending and receiving client information should be located in a secure area rather than in a common area where the information could inadvertently be mixed with other papers or inappropriately viewed.
4. The client's or legally guardian's authorization shall be obtained before releasing information, except in circumstances in which consent is not required.
5. Because the client record serves as the official record of events and clinical services provided to the client, the faxed document should be included in the client record and should be of sufficient quality to be readable and durable. Thermal paper should be photocopied.
6. Verification of signatures should occur routinely, comparing the faxed signature to an original in the record.
7. The fax cover sheet should contain a statement prohibiting redisclosure.
8. If a fax is misdirected, the fax machine's internal logging system should be checked for the misdialed number, the incorrect recipient contacted and asked to destroy the document and return it by mail, and an incident report should be submitted.[5]

5

Laura Feste, Guidelines for Faxing Patient Health Information, 62 J. of the Am. Med. Rec. Ass'n 29 (June 1991)

E-MAIL COMMUNICATIONS

Like the rest of the business world, health care providers increasingly are using electronic mail to conduct business--the key difference is that health care providers capture sensitive information about clients as well as information that may be essential to protecting the provider in the event of suit. The following recommendations are offered to minimize risk in the use of e-mail:

1. A policy shall be adopted which requires confidential handling of e-mail to the extent of any other client-related document.
2. Remember that e-mail is discoverable in litigation, law enforcement actions, and governmental investigations.
3. Document retention policies should address e-mail communications, including those stored electronically and in paper form. E-mail should be treated like other correspondence, or if it constitutes an order or client note, it should be stored with the client record (electronically or in printed form). E-mail should be retained if it directly relates to client care, justifies the treatment or the right to reimbursement, or otherwise fills the same function as other client record information.
4. Inconsistencies in e-mail messages as compared to final conclusions in the client record or in reimbursement requests could be used against the provider in a malpractice case.
5. The informality of e-mail causes unjustified laxness in communications. A policy should be adopted which reminds users that the e-mail should be viewed as a formal memorandum which may eventually get into the hands of parties not contemplated at the time.
6. Like faxes, confirm receipt of e-mails.
7. Information too sensitive to be reduced to writing should not be sent by e-mail.
8. If e-mail will be communicated externally, assurances should be obtained that the sender and receiver have confidentiality practices in place and that the e-mail is accessible only by that individual by password or other authentication.
9. E-mail which directly or indirectly identifies clients should be encrypted. This is particularly important if it will be sent over the Internet.
10. Remember that once sent, control of e-mail is lost. It can be forward, download and printed.
11. E-mail can be delivered in minutes or in days. A phone call may be warranted if information must be communicated urgently, or to confirm receipt.
12. E-mail containing peer review privileged information merits the same sensitivity as e-mail about clients.

COMPUTER VENDORS AND TECHNICAL SUPPORT SERVICES

To develop, install or maintain computer hardware and software, it sometimes is necessary to permit "third party" computer vendors and repair persons to have access to the computer system. Unlike health care providers, such individuals may not have the strict legal and ethical obligations to hold information confidential. It is recommended that a binding contract be entered which requires the third party to:

1. Keep records strictly confidential;
2. Not disclose health, competitive or other information acquired while working on the system;
3. Limit use of records only to those purposes necessary to carry out the contract;
4. Not install any virus, key blocks, or other programs into the system;
5. Require any employees, subcontractors or agents to also sign confidentiality agreements;
6. Provide confidentiality training for employees;
7. Return any records downloaded or printed and destroy any back-up copies; and
8. Provide indemnification for any breach of these obligations

- Third parties who may need access to data may not need access to client identifiers.
- "Dis-identify" data whenever possible. In addition, to the extent possible when client-identified information is necessary, access should be limited to a select group of the third party personnel;
- Clearly delineate ownership rights in data. Control over use of data flows with ownership rights.[7]

6

Many of these recommendations are drawn from E. Belmont & A. Waller, Information Linkages for Integrated Delivery Networks, AAHA annual meeting (June 1996); and from D. Miller, Internet Security: What Health Information Managers Should Know, 67 J. of AHIMA 56 (Sept. 2996).

7

Adele Waller and Deborah Fulton, The Electronic Chart: Keeping It Confidential And Secure, 26 J. of Health & Hosp. L. 108 (Apr. 1993).

Acknowledgment

Thanks to Barbara Bosma Garlock and Kilpatrick Stockton LLP for the use of their publication, Electronic Health Care Information: Minimizing Security and Confidentiality Risks.

Appendix F

LEGAL PROCEEDINGS

LEGAL PROCEEDINGS

Note: This section provides guidelines and requirements for area facility staff relative to legal proceedings involving client and service records. If the imperative "shall" is used, it is because other rules, such as CONFIDENTIALITY RULES, establish the requirement.

1. Compliance with Court Requests:

Client record personnel or other designated staff in area facilities shall comply with any valid requests issued by the court. Failure to do so may result in punishment by the court.

2. Receipt of Court Order, Subpoena or Interrogatory:

The area facility's attorney should be consulted whenever a court order, subpoena, or interrogatory varies from standard practice. Procedures for responding to court orders, subpoenas (for deposition, to appear as a witness in court and/or to produce documents or objects), and interrogatories are as follows:

a) Jurisdiction for subpoenas and court orders are as follows:

1) Valid subpoenas or court orders issued within the state of North Carolina must be honored. The distance necessary to travel within the state in order to honor a subpoena or the amount of prior notice for an order to appear in court has no bearing on whether or not a subpoena must be honored.

2) Subpoenas or court orders issued by out-of-state courts, except Federal Courts as explained in (a)(3) of this Section, are usually not valid but consult the area facility's attorney.

3) Subpoenas to appear in court which are issued by a Federal court in this State, anywhere within the Federal court's district, and anywhere outside the Federal court's district that is within 100 miles of the place of hearing or trial shall normally be honored but consult the area facility's attorney.

4) Court orders issued by a federal court judge should be honored but consult the area facility's attorney.

b) Verify that the individual/client whose service record has been requested is/or has been served by the area facility. If the individual/client cannot be identified, the custodian shall notify the person who requested the information or issued the court order that the individual cannot be identified. Notification, if made orally, shall be confirmed in writing.

1) If the service record is available in the area facility, it should be reviewed to determine whether it contains information about the individual/client in connection with treatment or activities related to drug or alcohol abuse. If so, the following shall apply:

a. The service record and/or any information contained in it shall not be released unless either:

- the client or his legally responsible person signs a proper consent form authorizing the release of the requested information, or
- a court orders the facility to release specified information after giving the facility and client an opportunity to be heard and after making a good cause determination under 42 C.F.R., Part 2 - "Confidentiality of Alcohol and Drug Abuse Patient Records" (Federal register publication, Vol. 52, No. 110, June 9, 1987).

b. If the facility has not received a court order or proper consent form for the release of the requested information, the issuer of the request shall be notified immediately that the request cannot be complied with and the reasons therefor. However, do not indicate directly or indirectly that the client is or has been a substance abuser. This notification, if made orally, shall be confirmed in writing and a copy of the written notification shall be placed in the service record.

c. When the request cannot be honored, it is recommended that the custodian of records who has been served with a subpoena appear in court at the date and time specified in the subpoena. The custodian should advise the judge that he/she notified the issuer of the subpoena that the facility would be unable to comply with the subpoena because of the Federal confidentiality law and regulations. If possible, a copy of the Federal regulations should be taken into court to show the judge and attorneys. The custodian should comply with orders issued by the judge.

d. If a proper consent form or court order has been received, the custodian shall proceed according to 2(d) through 2(f) in this section.

2. If the service records does not contain information about treatment or other activities related to drug or alcohol abuse:

a. The service record and/or any information contained in it shall not be released unless either:

- the client or his legally responsible person signs a proper consent form authorizing the release of the requested information; or
- a court of competent jurisdiction issues an order compelling disclosure; or

b. Following the determination that a subpoena or court order is valid and the service record is in the custody of the area facility, the responsible professional and the individual/ client or legally responsible person should be notified that the subpoena or court order has been received. This notification should be documented in the service record.

c. When an interrogatory has been received, information in the record may be released pursuant to a court order.

d. When a court order has been received which does not require an appearance in court, read the order thoroughly and submit only the information requested in the order to the designated party.

e. When a subpoena for deposition has been received, the person issuing the subpoena should be contacted to determine if a judge will be present at the deposition. If a judge will not be present, a court order (oral or written) must be obtained so that service record information can be disclosed as specified in G.S. 122C-54.

f. Client Records should be prepared as follows:

1. When a court order or subpoena has been received wherein the client record custodian or other designated staff is ordered to produce a service record in court or other official proceeding, the client record custodian or designee should review the entire record in order to become familiar with the record content and to ensure that the record is complete. All pages in the service record should be sequentially numbered and each page shall include the individual's/client's name, client record number (when assigned), and name of the agency.

   NOTE: The numbering of pages is a problem when an active client record is involved since more pages will be added to the record while the client remains active. It is recommended that, if the record is subpoenaed again at a later date, any page number changes be corrected by drawing a single line through the previous number and writing the new number beside the corrected number.

2. Review the subpoena or court order to determine if the entire record is to be presented in court or if only portions of the record are to be presented. If the subpoena specifies the entire client record is to be presented, no information (including information from other facilities) is to be removed from the record. Also, if any additional documents (such as x-ray films, laboratory slides, etc.) have been included on the subpoena or court order, these should be collected and kept with the service record whenever these documents are the property of the area facility.

   Contact the person issuing a subpoena in order to verify the date and time that the custodian will need to appear in court. Also ascertain if a certified copy of the record will be acceptable in lieu of the original. If the person issuing the subpoena determines that the original will be needed, the original record and a certified copy of the record shall be taken to the proceeding.

1. Whenever service records are copied for a judicial proceeding or in accordance with a court order, copy only those portions of the record specified in the subpoena or court order ensuring that all documentation on each individual page is included on the copies. The subpoena and/or court order shall also be copied and a letter of certification attached to the copies; and

   NOTE: Area facilities can certify records originated within the area facility; however, copies of records from other area programs or other facilities/agencies cannot be certified by the area facility custodian. Whenever information from another facility is included in a subpoena or court order, such information should be copied but should not be included with the certified portion of the record.

2. The letter of certification shall attest to the identity and authenticity of the records; that the copies are true and correct; that the records were made and kept in the regular course of business at or near the time of the acts, conditions or events recorded; and that they were made by persons having knowledge of the information set forth. The certification letter should be signed by the custodian and notarized. It is recommended that a separate cover letter be prepared notifying the clerk of court that the copy of the service record should be sealed and maintained in a secure location since the information is confidential and protected by state law. Also request that the clerk return the copy of the record to the area facility when it is no longer needed by the court. (Sample letters are located at the end of the section.)

3. Presenting Records in Court or Other Legal Proceeding:

a) Whenever a service record is taken to court or other legal proceeding, the record shall remain in the possession of the custodian or designee until otherwise instructed by the judge as specified in G.S. 122C-54(a).

b) Testimony is usually directed to the identification of the record; verification that the record was kept in the facility's regular course of business; content of the record; facility staff members responsible for documenting in the record including those portions of the record for which they are responsible; maintenance of the record; and record retention. The custodian or designee shall refrain from giving any opinion as to the quality of care recorded in the record.

c) Instructions given by the court to the custodian or designee are requirements of the court.

d) If pressed by an attorney for expression of an opinion, the custodian or designee should state that he/she is not qualified to answer the question.

e) Whenever an opposing attorney objects to a question in court, the custodian or designee should not answer the question until the judge has ruled whether or not the question is to be answered. (If this occurs during a deposition where a judge is not present to rule, answer the question unless the attorney representing the custodian instructs the custodian not to answer the question.) Whenever a judge "sustains" an objection, the custodian or designee shall not answer the question. Whenever a judge "overrules" an objection, the custodian or designee shall answer the question.

f) Whenever a record is to be presented into evidence, the custodian or designee should request that a certified copy of the record be accepted in lieu of the original record. If the court does not agree with this request, the custodian or designee should request that a receipt be prepared for the original record, signed by the clerk of court, designating that the service record will be sealed and maintained in a secure location and will be returned to the facility at the conclusion of the court process. The custodian or designee should not leave the courtroom without this receipt and should maintain the certified copy of the service record in the facility files until the original record is returned by the court.

4. Subpoenas or Court Orders - Family Records:

a) When a subpoena or court order is received for records on a client wherein the information is contained in a family record, the client record custodian should initiate negotiations with the court in an effort to protect information in the record relative to other clients included in the family record. The custodian should explain to the court that information pertaining to other clients is interwoven in the family record and, in order to protect the information, one of the following procedures should be requested:

1. a protective court order which requires the custodian to produce those portions of the record which specifically relate to the individual;
2. the preparation of a summary of information relating to the individual;
3. consent from all family members for the two opposing attorneys to review the family record and stipulate those portions of the record to be introduced in court and that names and references to other family members be obliterated; or
4. that testimony be given by the responsible clinical staff member based on his/her knowledge of the client and the record.

b) present the record in court or other legal proceeding has been received.

(Place on Agency Letterhead)

(Date)

TO WHOM IT MAY CONCERN:

RE:_____
(Client's Name)

I hereby certify that the enclosed medical record copies from _____(agency name) on the above-named individual are true and correct. The records were made and kept during the regular course of business at or near the time of the acts, conditions, or events recorded, and the records were made by persons having knowledge of the information set forth.

_____
(Custodian's Signature)

[Printed]
Custodian's Name
Agency Name
Agency Address

Sworn and subscribed before me the
____ day of _____, 19__.
_____

(Notary Public)

My commission expires:_____

NOTE: Copies of information received from _____
(Outside Agencies/Facilities) are also enclosed; however, I am unable to authenticate those copies.

(Place on Agency Letterhead)

(Date)

TO WHOM IT MAY CONCERN:

RE:_____
(Client's Name

I hereby certify that the enclosed medical record copies on the above-named individual are true and correct. The records were made and kept during the regular course of business at or near the time of the acts, conditions, events recorded, and the records were made by persons having knowledge of the information set forth.

_____
(Custodian's Signature)

[Printed]
Custodian's Name
Agency Name
Agency Address

Sworn and subscribed before me, the
_____ day of _____,
19_____.

_____
(Notary Public)

My commission expires:_____

Appendix G

DAY CARE REQUIREMENTS

Rule .0801 - Application for Enrollment

Legal Basis for Rule .0801

G.S. 110-91. Mandatory Standards for a License. -

The Following standards shall be complied with by all day care facilities, except as other-wise noted…

(9) Records. - Each day care facility shall keep accurate records on each child receiving care in the day care facility in accordance with a form furnished or approved by the Commission, and shall submit attendance reports as required by the Department.

Statement of Rule .0801 Application for Enrollment

(a) Each child in care shall have an individual application for enrollment completed and signed by the child's parent, legal guardian, or full-time custodian.

1. The completed, signed application shall be on file in the center on the first day the child attends and shall remain on file until the child is no longer attending.
2. The completed application shall include emergency medical information as specified in Rules .0802(b).
3. The completed application shall give the child's full name and indicate the name the child is to be called. In addition, the application shall include the child's date of birth and any allergies, particular fears, or unique behavior characteristics that the child has.
4. The application shall include the names of individuals to whom the center may release the child as authorized by the person who signs the application.

(b) Each child's application shall be readily available and easily accessible to caregiving staff during the time the children are present.

History Note: Statutory Authority G.S. 110-91(9); 143B-168.3;
Eff. January 1, 1986
Amended Eff. November 1, 1989.

The Intent Rule .0801

To ensure that facilities have complete and accurate personal information for each child.

Explanation of Rule .0801

Each child must have an accurately completed application on file on the first day of attendance. The application must be signed by the child's parent or guardian. Brother and sisters cannot share an application form. (Sample in Resource Section)

The applications on file must be accessible. An "accessible" file means that staff must be able to reach that file at all times. If the file is kept locked, the staff must have keys, or one key must be kept in a place available to every staff member.

Applications should be reviewed as needed to update any important information that might have changed. Examples of most required forms are listed in the resource section of this manual. Facilities do have the option of developing some of their own forms.

If facilities choose to develop their own application form, it must include every item of information found on the sample form. (See Resource Section)

Helpful Hints

In an emergency situation the facility staff might need to be able to grab records, applications, enrollment lists, etc. Alphabetizing applications and placing them in individual folders would be best if the emergency involved just one child or just a few children. However, some emergencies could involve the entire facility. (fire, severe storms, etc.) In situations like this it might be more helpful to have just one binder with a complete list of the children enrolled. To provide for both kinds of emergency, a facility might consider keeping both an up-to-date enrollment book that includes all the children and individual alphabetized folders for each child's application along with any other information relating to each child.

Application Date _____
Date of Enrollment_____

CHILD'S APPLICATION FOR DAY CARE

To be completed and placed in file prior to enrollment

Name of Child _____ Birthdate _____
(Last) (First) (MI) (Nickname)
Addresss_____Zip Code _____

INFORMATION ABOUT THE FAMILY:

Father/Guardian's Name _____Home Phone _____
Address_____ Zip Code _____
Where Employed _____Business Phone _____

Mother/Guardian's Name_____Home Phone_____
Address_____Home Phone_____
Where Employed _____Business Phone _____

Insurance Carrier _____Policy # _____

INFORMATION ABOUT YOUR CHILD

Does your child have any known allergies: No_____ Yes_____
Explain:

Please give any information concerning your child which will be helpful in his experience in group setting (such as play, eating and sleeping habits, special fears, special likes or dislikes). _____
_____

EMERGENCY CARE INFORMATION:

Name of child's doctor _____Office Phone _____
Address_____
Name of child's dentist _____Office Phone _____
Address_____
Hospital Preference _____Phone _____
If neither father nor mother (or guardian) can be contacted, call (please list relationship):
Name_____Home Phone _____Office Phone _____
Name _____ Home Phone _____Office Phone_____
If you cannot call for your child, please give the names of persons to whom the child can be released:
_____
_____

I agree that the operator may authorize the physician of his/her choice to provide emergency care in the event that neither I nor the family physician can be contacted immediately.

_____
(Signature of Parent) ..... (Date)

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian. Provisions will be made for adequate and appropriate rest and outdoor play.

_____
(Signature of Operator) (Date)

Children's Medical Report

Name of Child _____Birthdate_____

Name of Parent or Guardian _____

Address of Parent or Guardian _____

A. Medical History (May be completed by Parent)

1. Is child currently under a doctor's care? No _____Yes_____ If yes, when and for what?
_____
2. Is the child currently under a doctor's care? No_____ Yes_____If yes, for what reason
_____
3. Is the child on any continuos medication? No_____ Yes_____ If yes, what? _____
_____
4. Any previous hospitalizations or operations? No _____ Yes_____ If yes, when and for what?
_____
5. Any history of significant previous diseases or recurrent illness? No_____ Yes_____: Convulsions No_____ Yes_____: Heart Trouble No _____Yes_____
If others, what/when? _____
6. Does the child have any physical disabilities: No_____ Yes_____ If yes, please describe:
_____
Any mental disabilities? No _____Yes_____If yes, please describe: _____
_____
Signature of Parent or Guardian _____

B. Physical Examination: This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the N.C. Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DEHNR standards for EPSDT program. Height_____% Weight _____%
Head _____Eyes _____Ears_____Nose_____ Teeth_____
Throat_____Neck_____Heart_____Chest_____Abd/GU_____
Ext._____Neurological System _____Skin_____
Results of Tuberculin Test, if given:
Type_____Date_____Normal_____Abnormal_____
Should activities be limited? No_____Yes_____ If yes, explain:_____
_____
Any other recommendations:_____
_____
Signature of authorized examiner/title_____
Date of Examination_____Phone number_____

(continued on back)_

Office Address
(may use address stamp)

C. Immunization History: The day care operator or health official must enter the date immunization was received in the space below or attach a copy of the immunization record. G.S. 130A-155(b)requires all day care facilities to have this information on file.

Enter date of each dose - Month/Day/Year

VACCINE	#1	#2	#3	#4	#5
***DTP/DT** (circle which)					
***Polio**					
****Hib**					
***MMR** (combined dose)					
Measles (single dose)					
Mumps (single dose)					
Rubella (single dose)					
Other					

***Required by State Law.**
****Required by State Law for children born on or after 10/1/91**

Days of Attendance

Child's Name	Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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Appendix H

PURPOSE OF CLIENT AND SERVICE RECORDS

PURPOSE OF CLIENT AND SERVICE RECORDS

The term "client" is used restrictively in these manuals to only include individuals for whom an official admission is made and for whom a "client record" is opened. Area programs provide some services (i.e., screenings, assertive outreach, case consultations, etc.) to recipients who do not become "clients" of the area program. This distinction is made in order to differentiate between the terms "client record" and "service record" which should not be considered synonymous. In the most general sense a "client record" is a sub-type of "service record".

Client records, which are one type of service records, are maintained in order to:

1. provide a basis for planning client care and for ensuring continuity in the evaluation of the client's condition and treatment/habilitation;
2. document the course of the client's evaluation, treatment/habilitation and changing conditions;
3. document communication between the responsible clinical staff member and any other health care professionals contributing to the client's care;
4. enable the responsible clinical staff member to:
   a) provide effective continuing care to the client;
   b) determine the client's present or past condition at any specific time; and
   c) review the diagnostic formulation and therapeutic interventions and the client's response to treatment/habilitation;
5. enable another clinical staff member to assume the care of the client at any time;
6. enable a consultant to render an opinion after an evaluation of the client and a review of the client record;
7. serve as a basis for review, study and evaluation of the care rendered to the client;
8. assist in protecting the legal interests of the client, the area facility and its clinical staff members, and the Division;
9. provide data for use in continuing education and research;
10. substantiate all billings for service submitted by the area facility and/or client;
11. enable the retrieval of pertinent information required for utilization review and quality improvement activities; and
12. document information which may be needed by the client seeking eligibility for entitlements or other appropriate services.

Service records have some similar purposes, particularly as they provide evidence of staff activity for Division billing. In some cases, service records document recipient-specific characteristics and behaviors in order to enable continuity of care in case the recipient were to become a client.

Appendix I

BASIC RULES FOR DOCUMENTING IN SERVICE RECORDS

BASIC RULES FOR DOCUMENTING IN SERVICE RECORDS

1. The Division recommends entries in service records be:
   a) **accurate**-document the facts as observed or reported;
   b) **timely**-record significant information at time of event since delays may result in inaccurate or incomplete information;
   c) **objective**-record the facts and avoid drawing conclusions. When professional opinion is expressed, it must be phrased to clearly indicate that it is the view of the recorder;
   d) **specific, concise and descriptive**-record in detail rather than in general terms; be brief and meaningful without sacrificing essential facts, and thoroughly describe observations and other pertinent information;
   e) **consistent-**explain any contradictions and give the reason for the contradiction;
   f) **comprehensive, logical and reflective of thought processes**-record significant information relative to a client's condition and course of treatment/habilitation. Document pertinent findings, services rendered, changes in the client's condition and the client's response to treatment/habilitation. Information in the record shall include justification regarding the need for services initially and continued treatment/habilitation needs. Whenever atypical treatment/habilitation is utilized, document the reasons for this; and
   g) **clear**-record meaningful information, particularly for other clinicians involved in the client's care. Write in nontechnical terms, to the extent possible.
2. Remarks that are critical of treatment/habilitation carried out by others, that indicate bias against a client, or that are unprofessional, should not appear in a service record unless accompanied by a statement reflecting the need for the documentation of the information. Such remarks, if made, cannot be obliterated.
3. When making record entries, continuous entries for each service are necessary in order to minimize problems of improper chronological sequence and to avoid suspicions relative to inappropriate alterations in the record. In addition, both sides of a form should be used whenever practical in order to save space in the record.
4. With the exception of family/marital records, notations in the record of one client shall not personally identify other clients. Whenever references are made in a client's record about other clients, the other clients may be referred to by using initials, client record numbers, or letter/numbers, etc.
5. The use of names of "non-clients" (e.g. spouse, sibling, girl friend) in the client record should be limited to those situations wherein the responsible professional determines that use of the individual's name is clinically pertinent. Any person who has a significant influence on the client may be included by name as long as the extent and type of relationship and specific influence are also recorded. However, when "non-client" names are included in the client record, such information should be reviewed prior to any release to determine if the information should be disclosed.
6. If a page is to be copied from a client record, each copy should include the client's

name and record number. This practice will provide protection from legal questions regarding copied material.

7. When record content requirements are omitted from the service record due to clinical complications, the reason for the omission should be documented in the record (e.g. "physical exam unable to be performed on admission due to client's combative behavior", "client in inpatient services-service plan will be updated upon return to outpatient center"). Omitted information needs to be completed as soon as the client's condition/circumstances warrant such completion.
8. Plottings or graphs in client records do not have to be signed by the staff member plotting the information. Any notes in the client record which assess the progress, regression or trends displayed in the graph must be signed by the staff member making the assessment.

Appendix J

GENERAL SERVICE RECORDS INFORMATION

GENERAL SERVICE RECORDS INFORMATION

1. Lost or Destroyed Service Records:

Whenever an original service record or portions of the same cannot be located following a thorough search for the record and allowing a reasonable period of time for the record to "surface" or is destroyed by fire, water, shredding, etc., the area facility retaining custody of the record shall attempt to "reconstruct" the record as thoroughly as possible. Reconstructing a record which has been lost or destroyed may be accomplished in part through collection of the following information:

a) contact any persons who routinely receive copies of service record information (e.g., commitment papers sent to clerks of court; copies from the record sent to state facilities; copies maintained by the case manager; staff members who maintain file copies of assessment reports) and request that a copy of the information be returned to the area facility;

b) if available, check any logs or files on release of information to determine if information from the service record in question was released. This may include information released by client record personnel, the billing/reimbursement section or admitting office. If so, contact the person/agency which received the information and request that a copy of the information be returned to the area facility;

c) collect all file copies of client information which are routinely maintained in various departments within the area program or through contracted services (e.g., laboratory reports, physician orders from pharmacy);

d) contact clinical staff members who worked with the client to determine if they maintained any notes on the case in their personal files. Using these notes and memory, request that the clinical staff member formulate a summary of the client's case to date;

e) if copies of various reports from the service record can not be located and the client remains in service, the client should be reassessed and a new service plan developed as soon as possible;

f) formulate a new service plan utilizing any available documentation. Include an explanation in the record regarding the reason for the destruction or loss of the record and the amount of information which was lost or destroyed. Specify in the record that the client record has been reconstructed and the date the record was reconstructed; and

g) complete an incident report relative to the lost or destroyed record(s). The incident report should be referred to an appropriate committee or individual within the area program in order to determine if all possible actions to restore the record have been taken and to determine if new policies and procedures need to be developed in order to avoid a recurrence of the problem in the future.

2. Adoption Records

When a client is adopted, the identity of the natural parents and natural family shall be protected. The service record should not be sealed as the record often contains information important to the ongoing treatment of the client but rather a procedure should be developed whereby the information contained in the record would not disclose the identity of the natural family. One procedure would be to copy the pages in the original record which contain such identifying information and remove from the copied pages the identifying information. This copy would be filed in the client's record with the original information maintained separate and apart from the record. The original material shall be protected as to not allow disclosure to any parties.

Information generated on the client prior to the adoption may be released per the adoptive parent's authorization.

3. Transporting Records

Original service records may be removed from an area facility under the following circumstances:

a) in accordance with a subpoena to produce documents or objects, or other court order or when client records are needed for district court hearings held in accordance with Article 5 of Chapter 122C of the N.C. General Statutes;

b) whenever service records are needed for treatment/habilitation or audit purposes, records may be transported between area facilities;

c) in situations where the facility determines it is not feasible or practical to copy the client record or portions thereof, client records may be securely transported to a local health care provider, provided the record remains in the custody of a delegated employee;

d) whenever a client expires at an area facility and an autopsy is to be conducted, the record may be transported to the agency wherein the autopsy will be performed, provided the agency indicates an understanding of the requirements governing confidentiality by signing a statement of understanding and compliance as specified in the CONFIDENTIALITY RULES (Division publication APSM 45-1).

Appendix K

RECOMMENDED CLIENT RECORD POLICIES

RECOMMENDED CLIENT RECORD POLICIES

Although the following client record policies are not required, the area program and contract agency should closely reviewed the policy(ies) to determine which would be helpful in the development and maintenance of the service records and the documentation of services.

a) the requirements for documentation of referrals and transfers of clients between area program services;
b) procedures for the assignment of area program client record numbers;
c) when a child (client) is adopted, procedures to follow to protect in the service record the identity of the natural family;
d) the maintenance of a system which reflects the client's current diagnosis(es);
e) a tracking system which reflects the service(s) a client is receiving.

Appendix L

MISCELLANEOUS RECORDS/REPORTS

MISCELLANEOUS RECORDS/REPORTS

1. **Worksheets and Raw Test Data:**

   - Quantitative review worksheets/reminders may be included in the client record to designate documentation deficiencies but it is recommended that such worksheets/reminders be removed from the client record following completion of documentation deficiencies. Quantitative review worksheets can be destroyed whenever they are no longer needed by the area program.
   - It is recommended that qualitative review worksheets not be incorporated into the client record. These worksheets should be retained as a supporting document in accordance with the RECORDS RETENTION AND DISPOSITION SCHEDULE FOR STATE AND AREA FACILITIES, Division publication APSM 10-3.
   - It is recommended that raw test data (e.g. psychological tests, EEG tracings) not be incorporated into the client record. The data should be summarized and entered on the appropriate form in the client record. Raw test data should be retained in accordance with the RECORDS RETENTION AND DISPOSITION SCHEDULE FOR STATE AND AREA FACILITIES, Division publication APSM 10-3.

2. **Copies in the Service Record:**

   The service record is a legal document and should contain original material. Material generated within an area program should be placed in the service record in original form; however, copies of the following information are acceptable:

   - copies of commitment papers;
   - copies of correspondence;
   - identification/face sheet information;
   - copies of laboratory reports; and
   - copies of release of information forms

3. **Financial Records:**

   Financial information (e.g., client fee setting computation, correspondence relative to payment of bills, etc.) is not considered a part of the service record and should be kept separately. However, limited financial data (e.g. as the insurance carrier, financial data necessary to formulate a service plan for a client, CAP-MR/DD Cost Summary, IFSP, authorization for services) may be documented in the service record.

4. **Miscellaneous Information:**

Miscellaneous information such as newspaper clippings, photographs, letters or papers, drawings, etc. may be filed in the service record whenever the responsible clinical staff member determines that such information is relative to the clinical care or understanding of the client.

Appendix M

FAMILY/MARITAL RECORDS

FAMILY/MARITAL RECORDS

1. General:

The Division discourages the use of a family/marital record system because of possible legal ramifications relative to the confidentiality of information, as well as the potential for revenue losses from third party payors. Individual client records for each family/marital member targeted for active treatment/habilitation is preferred; however, **if an area facility elects to use the family/marital record concept, the following is recommended.**

2. Opening the Family/Marital Record:

Each member of the family/marital unit who has clinical symptomatology should be given a client record number, and identification/face sheet information should be completed and a family/marital record should be opened. If any of the family/marital members had a client record number assigned previously, this number should be utilized and a new number should not be issued. However, the client's former record should not be combined with the family/marital record.

3. Filing:

The family/marital record should be filed according to the designated case head's client record number or name. All identification/face sheet information should be filed in the family/marital record with the case head's form being placed on top. Whenever name labels are placed on the outside of client records, the label on the family/marital record should include the name and client record number of each member in the family/marital unit with the case head's name and number listed first.

4. Master Client Index:

Each member of the family/marital unit should be included in the master client index with a cross reference to each member. An asterisk (*) or other means of identification should designate the case head on the master client index.

NOTE: For manual master client indexes, the area program may elect to use a different colored index card to designate family/marital members. If a client has an individual index card prior to or following family/marital therapy, the two cards should be attached.)

When other family members are added to the family/marital unit following the initial opening of the record, their name and client record number should be added to the master client index and cross references to other family/marital members updated.

5. Change in Status of Family/Marital Unit Members:

When a member of a family/marital unit ceases to be a group member and enters individual therapy, the following procedures should be followed:

- remove the member's identification/face sheet information from the family/marital record;
- an entry should be included in the master client index (member and cross references) designating the member's transfer out of family/marital therapy and the date the client entered into individual therapy;

NOTE: If the member transferring to individual therapy is the assigned case head, another case head will need to be identified and record labels and the master client index changed accordingly.

- open a new client record utilizing the same identification/face sheet information and client record number;
- a clinician should update the client profile on the individual which includes summary information relative to the previous family/marital therapy session, and an explanation for the change to individual therapy;
- any individual notes or assessments relative to the client in the family/marital record should be transferred to the individual record.

6. Discharge of One Member of a Family Group:

Whenever an entire family/marital group is not discharged simultaneously, the following procedures should be followed:

- the identification/face sheet information should be closed out on the member being discharged in accordance with the STATISTICAL REPORTING REQUIREMENTS FOR AREA PROGRAM SERVICES, Division publication APSM 70-1;
- an entry should be included in the master client index (member and cross references) designating the member's date of discharge; and
- a discharge summary should be completed for the member terminating from the group, if required by local policy.

7. Documentation Requirements:

a) Client Profile: The clinical staff member will have the option of doing the following:

- an individual client profile for each member of the family/marital unit; or
- incorporate all required information with the exception of mental status and diagnoses into one report for each family/marital member including each member's name and client record number on the report. A diagnosis and mental status should be completed for each member of the family/marital unit. V-codes are appropriate for some family members.

b) Dates of Service: The dates of service events shall be recorded for each member.

c) Duration of Service: The progress notes shall include the duration of services.

d) Service Plan: The clinical staff member will have the option of doing the following:

- one joint service plan for the entire family/marital unit incorporating all of the family dynamics into one plan. However, an individual established diagnosis should be given for each client and the other clinical documentation on the service plan should support these diagnoses. Goals should be documented for each member of the family/marital unit. Each member's name and record number should be included on the joint service plan; or

- an individual service plan for each member of the family/marital unit.

e) Service Notes: The clinician will have the option of doing the following:

- one individual service note for each member of the family/marital unit; or
- one service note for all members of the family/marital unit. The joint service note must document each individual member's progress towards his/her goal on the service plan as clearly as an individual note. Each member's name and record number should be included on the joint service note; or
- an individual service note is required when members of the family/marital unit are seen for outpatient therapy independently of each other.

f) Physician/Medication Orders: Each member of the family/marital unit that is prescribed medication must have his/her own individual physician/medication orders sheet with client name and record number documented.

g) Evaluations: Any evaluations performed should be done on an individual basis, and therefore should be documented individually for each client evaluated.

h) Consent Forms: An individual consent form must be obtained from each member of the family/marital unit, when appropriate.

i) Discharge Summary: If required by area policy, the clinician should have the option of doing the following:

- an individual discharge summary on each member of the family/marital unit; or
- a combined discharge summary for all members of the family/marital unit incorporating all the information required for each member of the family/marital unit. However, individual diagnoses must be documented for each member of the family/marital unit.

j) Confidentiality:

- Members of the family/marital unit should be informed that all documentation is going into one record and that the possibility of a subpoena or court order for the entire record does exist.
- If information to be released is for one individual family/marital member only, and the information to be released speaks specifically to that individual, then his/her authorization would be required.
- It may be necessary in some cases for a summary to be prepared which speaks to the information regarding one individual only.
- A family/marital therapy member is authorized to review only those portions of the record in which the individual participated or evaluations which pertain only to the individual making the request.
- If information to be released involves more than one family/marital member, the authorization of each involved member is required.

Appendix N